Referral/Consult

Date: ______________________________

Referring Physician: ______________________________

Procedure: ______________________________

Physician: ______________________________

Phone: ______________ Fax: ____________

Patient Name: ______________________________

DOB: ______________________________

Diagnosis: ______________________________

Code: ______________________________

❑ Consult & Treat ❑ Consult Only

An authorization has been requested from Dr. ____________________ (Primary Care Physician) to be sent to your office. Please schedule patient when you have received the authorization.

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Physician Signature

Fax this consult form to:

Downtown	*904.391.5545*	*Lakewood*	*904.636.5786*
Beaches	*904.249.9764*	*South*	*904.292.4805*